



DEPT. OF PATHOLOGY AND LABORATORY MEDICINE

# Specimens:		
Collect Date:	Time:	By:
MR #:	A #:	

REQUIRED (PRINT OR PATIENT LABEL)	
Name (Last, First, MI)	
Date of Birth	Sex: (circle) M F
Social Security Number	
Street Address	
City, State, Zip	
Phone Number	Client Number
Indicate primary (1) and secondary (2) insurance ___ Blue Cross/Shield ___ Child Health Plus ___ Preferred Care ___ Blue Choice ___ Medicaid ___ Preferred Care Gold ___ Blue Choice Senior ___ Medicare ___ Aetna ___ Other _____ 1. Primary Contract #: _____ Subscriber's Name: _____ Relationship to Subscriber: _____ 2. Secondary Contract # _____ Subscriber's Name: _____ Relationship to Subscriber: _____	

Phone Results to:	Fax Results to:
Ordering Provider's Signature	
Send Additional Reports To: (Full Name/Address)	
<small>Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered. It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.</small>	

NEUROMUSCULAR SPECIMENS

Biopsy Date:	BIOPSY SITE (DESCRIBE SITE OF BIOPSY PRECISELY):	TYPE OF BIOPSY
Collection Time:		<input type="checkbox"/> Muscle <input type="checkbox"/> Nerve <input type="checkbox"/> Skin

RELEVANT CLINICAL HISTORY (REQUIRED) DIFFERENTIAL DIAGNOSIS/SPECIFIC QUESTIONS/LAB TESTS:	<input type="checkbox"/> See Attached Reports <input type="checkbox"/> CD Rom <input type="checkbox"/> Wet Tissue <input type="checkbox"/> Blocks <input type="checkbox"/> Slides
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Known Infection Risks (HIV, Hepatitis, etc):	Tissue Sent: <input type="checkbox"/> Formalin <input type="checkbox"/> Glutaraldehyde <input type="checkbox"/> Frozen <input type="checkbox"/> PLP
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